Supreme Court, U.S.
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No. 93-705

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

JOSEPH PUDLO, M.D.,

Petitioner,

v.

E. ADAMSKI, M.D.; J. SCHNEIDER, M.D.; S. BORUSHEK, M.D.; J. DADDINO, M.D.; GARY FAHRENBACK, M.D.; D. LARSON, M.D.; B. LEVY, M.D.; J. NABOLOTNY, M.D.; L. PANKAU, M.D.; V. VOHRA, M.D., individually, T.P. NASSOS, M.D.; E.W. BEUTEL, M.D.; Y. KIM, M.D.; J. COUGHLIN, M.D.; W. DAVIDSON, M.D.; F. GRABINER, M.D.; S. HADAWI, M.D.; F. MARIANO, M.D.; D.L. MEYERS, M.D.; E.A. PETRUS, M.D.; L. PUPILLO, M.D.; F. HEALEY, M.D.; A.R. MCCALL, M.D.; J. SCHNEIDER, M.D.; SISTER DONNA MARIE, Chief Executive Officer of the Hospital in their representative capacity; and RESURRECTION MEDICAL CENTER in Chicago, Illinois,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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RESTATEMENT OF QUESTION PRESENTED

I. Whether the courts below properly applied the *Copperweld* doctrine to dismiss Petitioner's Complaint where the Complaint alleged that the Resurrection Medical Center Board retained ultimate authority for the decision to terminate his medical staff membership and clinical privileges but solicited and received recommendations from various medical staff peer review committees pursuant to an express delegation of authority under the medical staff bylaws.

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RESPONDENTS' BRIEF IN OPPOSITION

Respondents respectfully request that this Court deny the petition for writ of certiorari filed by Joseph Pudlo, M.D. on November 4, 1993.

COUNTER-STATEMENT OF THE CASE[1]

Petitioner is an internist who was a provisional member of the Resurrection Medical Center (the "Hospital") medical staff in 1990-91. He filed this suit after the Hospital's Governing Board voted not to promote him to the Active Staff, thereby terminating his medical staff membership and clinical privileges.

A. The Peer Review Process.

All appointments to the Hospital's Medical Staff are provisional for a period of 15 months. (Comp. Ex. I at 6.)[2] In accordance with Article III, Section 5(a) of the Bylaws, the clinical competence and other qualifications of all provisional staff members are subject to close scrutiny during this probationary period. (Comp. Ex. I at 6.) Through the Bylaws, the Hospital delegates certain peer review functions to the medical staff. For example, the Bylaws expressly direct each department chairman to observe the performance of each Provisional Staff member holding clinical privileges within his or her department. (Comp. Ex. I at 6.) The chairman must consider reports from the Department of Quality Management/Risk Management ("QM/

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[1] Petitioner's "Statement of the Case" routinely omits citations to the Complaint or any other portion of the record. More importantly, Petitioner's purported rendition of the facts substantially distorts both the Complaint, which Petitioner did not place before the Court, and the decisions below. Under Supreme Court Rule 14.5, Petitioner's failure to present accurately the allegations which the courts below were asked to review is alone "a sufficient reason for denying the petition."

[2] The Amended Complaint, is cited as "Comp." throughout this brief. The Petition for Certiorari is cited as "Pet.". The Appendix to the Petition is cited as "App.".

RM"), which systematically reviews patient charts to detect deviations from quality and utilization standards, as part of the evaluation of Provisional Staff members and overall monitoring of the quality of care rendered in the Department. (Comp. Ex. I at 6, 17, 35-6.)

Upon the expiration of their 15 month tenure, Provisional Staff members are eligible for promotion to the Active Staff. (Comp. Ex. I at 6.) Provisional Staff members who are not promoted to the Active Staff automatically lose their medical staff membership and clinical privileges. (Comp. Ex. I at 6.) While the Hospital's Board considers recommendations from the relevant Department, the Medical Executive Committee ("MEC") and any other committee that reviews the physician, the Board retains the ultimate authority to determine whether a Provisional Staff member should be removed (promoted) to the Active Medical Staff. (Comp. Ex. I at 6.)

B. The Hospital's Evaluation of Petitioner's Qualifications for Removal.

In accordance with the foregoing procedure, Petitioner's charts were scrutinized by the Hospital's QM/RM personnel. (Comp. Ex. A.) These personnel uncovered charts evincing deviations from the Hospital's standard criteria. (Comp. Ex. A and C.) The charts were forwarded to Dr. Adamski, who was chairman of the Department of Internal Medicine, the department in which Petitioner held privileges. (Comp. Ex. A and C.) None of the Hospital personnel who selected the charts forwarded to Dr. Adamski are alleged to have been competitors of Petitioner. Nor was their review alleged to have been part of the "conspiracy" purporting to give rise to Petitioner's claim.

On June 17, 1991, and again on July 17, 1991, Dr. Adamski asked Petitioner to explain the deviations from QM/RM standards spotted by the non-physician administrative personnel who reviewed his records. (Comp. Ex. A and B.) Petitioner failed to respond to these requests, despite the fact that, under the Bylaws, he had the burden to establish his qualifications for clinical privileges. (Comp. Ex. B, E and I at 7.)

On July 17, 1991, Dr. Adamski asked Petitioner to explain deviations from Hospital standards reflected in another medical record reviewed by non-physician QM/RM personnel referred through the clinical pertinence screen. (Comp. Ex. C.) Petitioner also failed to respond to this request, even to explain that he was unable to respond because the records were unavailable. (Comp. Ex. E.)

Dr. Adamski then invited Petitioner to attend the August 1991 meeting of the Internal Medicine Committee. (Comp. Ex. E.) In his letter, Dr. Adamski emphasized that it was important that Petitioner explain the instances of apparent substandard medical practices if he wished to be removed to the Active Staff. (Comp. Ex. E.) This informal opportunity to meet with the Department and explain in writing the questionable medical practices under review is not required by the Bylaws. At the meeting, Petitioner was unable to explain the variation from the Hospital's QM/RM standards. (Comp. ¶21.) Consequently, the Department voted unanimously to recommend that Petitioner not be promoted to the Active Staff. (Comp. ¶¶9, 22). The Department is comprised of general internists, as well as specialists who do not compete in the alleged relevant market: general internal medicine services. (Comp. ¶¶7, 19.) As required by the Staff Bylaws, Dr. Adamski transmitted this recommendation to the MEC. (Comp. ¶22, Ex. I at 6.)

The MEC reviewed the departmental recommendation and supporting documentation, as required by Article III, Section 4(d) of the Bylaws. (Comp. ¶¶22, 25, Ex. I at 6.) Based on the documentation reviewed, the MEC also decided to recommend against promotion. (Comp. ¶24.) This recommendation, and the supporting documentation, were forwarded to, and reviewed by, the Board. (Comp. ¶24.) The Complaint does not allege that a single member of the Board competed with Petitioner. Yet, the Board also voted not to promote Petitioner to the Active Staff. (Comp. ¶24, Ex. I at 5-6.)

At his request, Petitioner was provided a hearing in accordance with Article VI, Section 3 of the Bylaws. (Comp. ¶25.) The Appeals Committee Chairman adopted hearing procedures, as required by Article VI, Section 3(b). (Comp. ¶¶27-28, Ex. I at 13.) Petitioner was entitled to present evidence and witnesses, including an expert witness, and was accompanied by his attorney. (Comp. ¶¶27-30.) Dr. Adamski was unaccompanied by counsel and was not as well prepared for the hearing as Petitioner and his attorney. (Comp. ¶29.) Based on the evidence presented, the Committee recommended that Petitioner be promoted to the Active Staff. (Comp. ¶34.)

The Appeals Committee's report and recommendation was forwarded to the MEC. (Comp. ¶33.) Article VI, Section 3(a) of the Bylaws requires the MEC to make its own recommendation following receipt of the Appeals Committee's recommendation. (Comp. at 13.) In other words, the MEC conducts a de novo review of the record and may accept or modify the Appeals Committee's recommendation based upon its review. (Comp. Ex. I at 13.) In this case, the MEC again recommended that Petitioner should not be promoted to the Active Staff. (Comp. ¶33.) This second adverse recommendation was forwarded to

the Board, together with the Appeals Committee's recommendation and all associated reports. (Comp. at Ex. ¶39.)

As mandated by the Staff Bylaws, the Board reviewed the recommendations of both the Appeals Committee and MEC. (Comp. ¶39, Ex. I at 13.) On November 14, 1991, the Board determined that Petitioner failed to satisfy the Hospital's standards for Active Staff membership and thus voted not to promote Petitioner to the Active Staff. (Comp. ¶ 39.) Consequently, Petitioner's medical staff membership and clinical privileges were automatically terminated. (Comp. ¶39.)

C. The Proceedings Below.

Petitioner sought damages and injunctive relief under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2. He alleged that the decision not to promote him to the Active Staff was the product of a conspiracy to restrain trade in, and monopolize the market for, general internal medicine services. (Comp. ¶ 7.) He relied on two possible conspiracy theories: 1) that the Hospital conspired with its medical staff or 2) that the individual members of the medical staff conspired among themselves. (App. 6.)

In March of 1992, the District Court issued its Memorandum Opinion and Order dismissing all of Petitioner's claims. The District Court rejected Petitioner's first conspiracy theory, holding that the Hospital was incapable of conspiring with its medical staff under the intra-enterprise conspiracy doctrine articulated by this Court in *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984) (hereinafter the "*Copperweld* doctrine"). The District Court then rejected Petitioner's second conspiracy theory on the grounds that, although medical staff members are capable of conspiring among themselves, the gov-

erning board's retention of ultimate authority for the termination of Petitioner's privileges made it "inconceivable a conspiracy among individual members of the medical staff was the actual cause of Pudlo's injury." App. at 10. The Seventh Circuit unanimously affirmed the District Court's decision in an unpublished order issued on August 9, 1993. App. at 14-17.

REASONS FOR DENYING WRIT

The petition arises from an unpublished decision by the Seventh Circuit Court of Appeals that has no independent precedential value. The petition does not present any conflict with Supreme Court precedent, it exaggerates the conflict among the circuits and involves no questions of general public importance.

I.

THE DECISIONS BELOW REPRESENT A SOUND APPLICATION OF SUPREME COURT PRECEDENT AND DO NOT PRESENT A MAJOR CONFLICT AMONG THE CIRCUITS WARRANTING THIS COURT'S REVIEW.

In order to entice this Court to grant his Petition for Certiorari, Petitioner touts the Seventh Circuit's opinion as expanding the *Copperweld* doctrine "beyond what any other United States Circuit Court of Appeals had done," thereby exacerbating what he labels "a profound conflict among the circuits on this very important issue." Pet. 8-9. Petitioner further bills the decisions below as going "against this Court's precedents on grants of immunities, against Congressional policy on enforcement of antitrust laws in this area of commerce and most importantly an unjust and unfair expansion of a narrow doctrine not suited for this case." *Id.*

In fact, the Seventh Circuit's unpublished, uncitable opinion did none of those things. Rather, it merely affirmed a district court's application of Supreme Court precedent to the facts alleged in the Complaint. In agreeing with the District Court that the Complaint failed to allege an actionable antitrust conspiracy, the Seventh Circuit went no further than the majority of other circuits to have considered similar claims—indeed the opinions below track the language and reasoning of several prior decisions that this Court determined did not warrant *certiorari*. The Seventh Circuit's fidelity to Supreme Court precedent, as interpreted by several other federal circuits, does not merit this Court's review.

A. The Courts Below Correctly Applied the *Copperweld* Doctrine To Hold That The Hospital Was Legally Incapable of Conspiring With Its Medical Staff Under The Facts Alleged In The Complaint.

The holdings below on the intra-enterprise conspiracy issue are consistent with this Court's opinion in *Copperweld*. First, the District Court correctly articulated the analysis required under *Copperweld* and its progeny:

> Whether the medical staff's relationship to the hospital is sufficiently analogous to an officer's relationship to the corporation involves an inquiry of "substance, rather than form." *Oksanen*, 945 F.2d at 703. Thus, a mere finding that the hospital's medical staff *sometimes* pursues economic interests apart from the hospital is inadequate to conclude that the hospital is *always* capable of conspiring with its medical staff. *See id.* (criticizing the *Bolt* court for ignoring the functional approach mandated by *Copperweld*). Rather, we must examine the substance, rather than form, of the hospital's relationship with its medical staff within the specific context of the peer-review process.

App. 8. *See also Weiss v. York Hosp.*, 745 F.2d 786, 815 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985) (*Copperweld* mandates a functional approach to determine whether an alleged intra-enterprise conspiracy is actionable).

The District Court then correctly applied that analysis by thoroughly examining the substantive aspects of the Medical Staff's relationship with the Hospital during peer review as alleged in the Complaint and exhibits thereto. App. 8-9. In particular, the District Court observed the exhibits to the Complaint established that the Hospital's Governing Board *delegated* peer review decision making in the first instance to the medical staff through the Bylaws, and that the actions of the defendant internists alleged in the Complaint were in accordance with these Bylaws. App. 8. The Court further observed that, to the extent individual members of the medical staff opted to pursue interests antithetical to those of the Hospital, the Governing Body retained the ultimate authority to reverse the decision.[3] Based on this analysis, the District Court properly concluded that the medical staff functioned as "an integral and natural extension of the Hospital's management structure, utilizing its expertise in medical care to make an initial determination of whether Petitioner had achieved a certain level of professional competence." App. 8-9.

Not only did the District Court strictly adhere to this Court's mandate in *Copperweld*, its ruling is consistent with the well-reasoned majority rule that has evolved in the context of medical staff peer review at hospitals. *Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 702-05 (4th Cir. 1991), *cert. denied*, 112 S. Ct. 973 (1992); *Nurse*

[3] Article III, § 4 of the Medical Staff Bylaws states "the Governing Body is responsible for the final decision based on medical staff recommendations, regarding an individual's reappointment and/or renewal a revision of individual clinical privileges."

Midwifery Assoc. v. Hibbett, 918 F.2d 605, 614 (6th Cir. 1990), *modified*, 927 F.2d 904 (6th Cir.), *cert. denied*, 112 S. Ct. 406 (1991); *Nanavati v. Burdette Tomlin Memorial Hosp.*, 857 F.2d 96, 118 (3d Cir. 1988), *cert. denied*, 489 U.S. 1078 (1989); *Weiss v. York Hosp.*, 745 F.2d 786, 814 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985). *See also*, *Purgess v. Sharrock*, 1993-2 Trade Cas. (CCH) ¶70,349 (S.D.N.Y. Nov. 9, 1992) (Chairperson of hospital's anesthesiology department lacked capacity to conspire with hospital to terminate physician's privileges); *Balaklaw v. Lovell*, 822 F. Supp. 892 (N.D.N.Y. 1993) (hospital's board, medical staff and trustees comprised single entity and were incapable of conspiring to violate Sherman Act); *Willman v. Heartland Hosp. East*, 1993-2 Trade Cas. (CCH) ¶70,412 (W.D. Mo. Oct. 19, 1993) (*Copperweld* doctrine applies to hospital peer review); *Okusami v. Psychiatric Inst. of Wash., Inc.*, 959 F.2d 1062 (D.C. Cir. 1993) (under *Copperweld*, complaint failed to allege conspiracy between hospital and physician medical director).

The Seventh Circuit's affirmance of the District Court's analysis likewise did not, as Petitioner contends, go "further than decisions of other circuits."[4] Rather, the Seventh Circuit carefully circumscribed its opinion:

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[4] Petitioners' continued insistence that the *Copperweld* doctrine is a "narrow doctrine not suited for this case" (Pet. 9) ignores the reality that the doctrine has been applied to a variety of economic relationships going far beyond the parent-subsidiary context. *Proctor v. General Conference of Seventh-Day Adventists*, 651 F. Supp. 1505 (N.D. Ill. 1986) (various unincorporated associations and separately incorporated book publishing/selling organizations aligned with the General Conference of Seventh-Day Adventists treated as single entity); *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986) (Blue Cross and Blue Shield appropriately treated as a single entity, even before merger, because they acted as one company for 30 years); *City of Mt. Pleasant v. Assoc. Elec. Co-op., Inc.*, 838 F.2d 268 (8th Cir. 1988) (group of related corporations comprising part of rural electric cooperative did not have requisite plurality to violate Section 1).

> We write separately only to note our agreement with the position taken by the Third and Fourth Circuits that under the doctrine of intra-corporate immunity, a hospital is legally incapable of conspiring with its medical staff during the peer-review process, when, as here, the medical staff acts with delegated authority to recommend action to the hospital's board, because the staff is acting in the same way that an officer of a corporation would act in relation to the corporation.

App. 16. The Seventh Circuit's circumspection also is evident in its declination to publish its opinion. As a result, the Seventh Circuit opinion has no independent precedential value, and cannot be cited as independent authority within or outside the Seventh Circuit. Thus, the opinion in no way exacerbated the nominal split among the circuits on the intra-enterprise conspiracy issue.

Indeed, the very contention that "there is a profound conflict among the Circuits" regarding the applicability of the *Copperweld* doctrine to hospital peer review (Pet. 9) ignores the reality that the Eleventh Circuit is the only circuit in this country to have held that a hospital is capable of conspiring with its medical staff in the context of peer review.[5] *Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990). This Court found the *Bolt* decision unworthy of *certiorari*, de-

[5] The Ninth Circuit, which held that a hospital and members of its medical staff were capable of conspiring outside the context of peer review in *Oltz v. St. Peter's Community Hospital*, 861 F.2d 1440 (9th Cir. 1988), has not formally considered the issue of whether a hospital is capable of conspiring with its medical staff *within* the context of peer review. Neither court below endorsed, nor did the Respondents advocate, a rule that would have precluded an antitrust conspiracy in a context outside clearly delegated peer review responsibilities.

spite that decision's creation of a split among the circuits. Since *Bolt* was decided, the Fourth, Sixth and Seventh Circuits, as well as district courts in the Second and Eighth Circuits, have adopted the Third Circuit's holding in *Weiss* on the intra-enterprise conspiracy issue. Thus, *Bolt* remains a singular anomaly.

The majority rule adhered to by the courts below represents a sound application of the *Copperweld* doctrine, which is premised on the principle that "a business enterprise should be free to structure itself in ways that serve efficiency of control, economy of operations and other factors dictated by business judgment without increasing its exposure to antitrust liability." *Copperweld*, 467 U.S. at 773. Delegating investigative and advisory peer review responsibility to a medical staff, while reserving ultimate authority in the governing body, allows hospitals to conduct statutorily mandated peer review activities[6] in the most effective and efficient means possible, namely by soliciting input from those who are in the best position to evaluate a physician's competence: the colleagues who work with him on a daily basis. *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1458 (11th Cir. 1991). This decisionmaking framework can enhance a hospital's reputation for quality and better enable it to compete in the hospital marketplace. *See Weiss*, 745 F.2d at 821 n.60 (effective

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[6] State law and accreditation standards promulgated by the Joint Commission on the Accreditation of Healthcare Organizations mandate that hospitals require their medical staffs to participate in the evaluation of the competence and qualifications of applicants for appointment and reappointment to the medical staff and to forward recommendations to the hospital's governing board, which is to retain final authority over all credentialling decisions. Ill. Hosp. Licensing Act Regulations, 77 Ill. Adm. Code §§ 250.210(a) and 250.310; Joint Commission on Accreditation of Healthcare Organizations, *Accreditation Manual for Hospitals* (1992) at MS.2.1.

peer review enhances a hospitals' reputation and the quality of care it delivers and is procompetitive). Yet, because a hospital and its medical staff are not competitors, the hospital peer review process does not represent "the sudden joining of independent economic forces that section one is designed to deter and penalize." *Oksanen*, 945 F.2d at 703; *Nanavati*, 857 F.2d at 118. *See Copperweld*, 467 U.S. at 769.

In *Copperweld*, this Court cautioned that adopting a rule that penalizes "coordinated conduct simply because a corporation delegated certain responsibilities to autonomous units might well discourage corporations from creating divisions with their presumed benefits." 467 U.S. at 771. The court in *Oksanen* heeded this warning:

> Penalizing coordinated conduct in the health care context would not only discourage hospitals from investing authority in their medical staffs, but it would also discourage staff members from accepting and exercising delegated authority if to do so involved the omnipresent fear of antitrust treble damages suits.

945 F.2d at 703-04. The opinions below are true to this ideal.

In sum, applying the *Copperweld* doctrine to the facts alleged in Petitioner's Complaint fosters economic efficiency and competition among hospitals without creating the dangers that the antitrust laws were intended to prevent. The lower courts' recognition that the Hospital and its medical staff functioned as a single enterprise in reviewing Petitioner's qualifications for promotion to the Active Staff is sound and does not warrant this Court's review.

B. The Courts Below Properly Concluded That The Complaint Failed To Allege Antitrust Injury.

The courts below also properly rejected Petitioner's second conspiracy theory based on the Complaint's failure to allege antitrust injury. Because the Complaint alleged that "the Hospital's governing Board retained ultimate responsibility for the decision of whether Pudlo's staff appointment would be terminated," it was "inconceivable" that a conspiracy among individual medical staff members was the actual cause of Petitioner's injury. App. 10 (citing *Oksanen*, 945 F.2d at 706). Even the Eleventh Circuit, the same circuit that decided *Bolt*, has recognized that, when a non-physician hospital board retains ultimate, unilateral authority for a credentialling decision, the solicitation of input from a physician's competitors through the peer review process does not give rise to an actionable antitrust conspiracy. *Todorov*, 921 F.2d at 1459.[7]

Petitioner mischaracterizes the holdings below when he asserts that the Seventh Circuit's decision "means that as a matter of law . . . members of the medical staff involved in . . . internal peer review [cannot] conspire with

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[7] As the Eleventh Circuit observed, *Todorov* involved facts that were "strikingly similar" to those in *Bolt*. 921 F.2d at 1446 n.13. Nonetheless, the Eleventh Circuit rejected Dr. Todorov's antitrust conspiracy claims, holding that where a hospital board unilaterally rejects a physician's application for privileges, competing physicians who recommend that privileges be denied are not causally responsible for that decision and thus cannot be liable under the antitrust laws.

The defendants in *Bolt* apparently did not argue that the Hospital's action was a unilateral one and that the defendant physicians were powerless to inflict the injury complained of by Dr. Bolt. The *Bolt* opinion contains no discussion of this argument and does not even consider whether the defendant hospitals had a motive for conspiring to deny Dr. Bolt's privileges. 891 F.2d 810.

other members of the medical staff." Pet. 9. Neither the courts below, nor Respondents, quibble with Petitioner's abstract assertion that, in some contexts, the individual members of a medical staff may be driven by competing economic interests and have the capacity to conspire. App. 9. Every corporate agent has independent interests that may be pursued outside the agent's corporate responsibility. *See Mandava v. Howard Country General Hosp.*, 1992-2 Trade Cas. (CCH) ¶69,932 (D. Md. July 1, 1992) (rejecting contention that physician acted as head of medical corporation rather than hospital agent during peer review). When agents act outside their delegated responsibility and/or there is evidence of coercion, perhaps a conspiracy could result. But that hypothetical was not before the courts below.

Rather, the Complaint alleges that Petitioner lost his privileges as a result of a peer review decision by the Hospital Board with input from various peer review committees comprised of physicians. Nowhere does the Complaint allege that the physicians had "captured" the Board or otherwise coerced the Board into denying Petitioner promotion to the Active Staff. Nor does it allege that the Board's decision resulted from physician actions taken outside the scope of delegated peer review duties. Under these circumstances, the courts below properly concluded that "although the medical staff is legally capable of conspiring with itself, no actual injury could possibly flow from the resulting agreement" alleged in the Complaint. App. 13.

This aspect of the District Court's holding, which was affirmed by the Seventh Circuit without discussion, goes

no further than the Fourth Circuit in *Oksanen*[8] and is not inconsistent with the Third Circuit's holding in *Weiss*, wherein the Third Circuit found that physicians exercised "control over York's admission decisions." 745 F.2d at 819. Indeed, as the Eleventh Circuit recognized in *Todorov*, Supreme Court precedent *requires* "a private party seeking to invoke the antitrust laws must show that the defendants caused the alleged injury."[9] 921 F.2d at 1459

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[8] Petitioner struggles to distinguish *Oksanen*, contending that *Oksanen* involved an action initiated by a hospital board while this case involves an action initiated by a competitor. Yet, the Complaint itself contradicts Dr. Pudlo's contention. The Exhibits to the Complaint demonstrate that the Hospital's QM/RM Department initiated the process by submitting charts of patients treated by Dr. Pudlo reflecting deviations from routine QM/RM standards to Dr. Adamski. (Comp. Ex. A and C.) Moreover, as the District Court recognized, the Hospital requires each department chairman to evaluate the Provisional Staff members in his department and recommend whether or not they should be removed to the Active Staff. App. 8. Thus, Dr. Adamski was acting at the behest of the Hospital when he investigated possible substandard care by Dr. Pudlo and when he transmitted his recommendation regarding Dr. Pudlo to the MEC. App. 8.

Petitioner also asserts that *Oksanen* is distinguishable because the peer review procedures followed by the medical staff in *Oksanen* were fair while those followed by the medical staff in this case were not. But neither the Fourth Circuit's opinion in *Oksanen*, nor the opinions in this case, turned on the fairness of the procedures. Rather, the inquiry focused on the medical staff's formulation of recommendations pursuant to a delegation of authority and the hospital board's retention of the ultimate authority for the credentialling decision, including the ability to discount recommendations that were antithetical to the hospitals' interests. Thus, this case is simply not distinguishable from *Oksanen*.

[9] *Todorov* also attests to the propriety of the lower courts' refusal to reach Petitioner's illogical vicarious liability theory. Petitioner argues that, even if the Hospital cannot conspire with its medical staff, it should be vicariously liable for the medical staff's conspir-

(Footnote continued on following page)

(citing *J. Truett Payne Co., Inc. v. Chrysler Motors Corp.*, 451 U.S. 557 (1981), *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104 (1986), and *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977)). This is the hurdle that Petitioner failed to clear in this case.

There is no split among the Circuits as to whether there need be a causal link between an alleged conspiracy and a plaintiff's alleged injury. Petitioner has cited no case to the contrary. Therefore, the non-controversial holdings below on antitrust injury do not warrant this Court's review.

II.

THIS CASE IS NOT INCONSISTENT WITH THIS COURT'S DECISION IN *PATRICK* OR CONGRESS' ENACTMENT OF THE HEALTH CARE QUALITY IMPROVEMENT ACT.

Petitioner attempts to pique this Court's interest with a parade of imaginary horribles. First, he maintains that the Seventh Circuit's opinion renders moot this Court's decision in *Patrick v. Burget*, 486 U.S. 94 (1988). Pet. 17. Second, he asserts that the decision contravenes congres-

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[9] *continued*

acy. Again, Petitioner is tripped up by the principle hurdle in this case: the Board—not the internists—terminated his medical staff privileges. Thus, he has not alleged any injury flowing from a conspiracy among the internists. It makes no sense to contend that the Hospital should be vicariously liable for a conspiracy that caused no injury.

It also should be noted that the petition does not offer the vicarious liability theory as an independent basis for review. Thus, under Supreme Court Rule 14, if this Court determines that the lower courts' holdings on intra-enterprise conspiracy does not merit review, Petitioner's vicarious liability theory cannot be an independent basis for *certiorari*.

sional intent as evidenced by the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.* ("HCQIA"). Pet. 19-20. Third, he claims that failure to grant review would exclude the health care industry from ordinary application of Section 1 of the Sherman Act. Pet. 10. All of these claims are plainly unfounded.

Petitioner's contention that the Seventh Circuit's decision somehow moots *Patrick* distorts Supreme Court precedent. *Patrick* involved an entirely different doctrine than is at issue in this case—the state action doctrine—which under the clear precedent of this Court could not be stretched to cover a hospital peer review process that was not actively supervised by the state. Petitioner's novel suggestion that *Patrick* requires a hospital to "actively supervise physician controlled peer review processes," Pet. 17, inappropriately interjects state action principles into the *Copperweld* analysis. The very premise of Petitioner's *Patrick* argument makes little sense—the courts below did not consider whether a *physician-controlled* peer review process would qualify for *Copperweld* immunity because the Complaint alleged a peer review process that was controlled by the Hospital Board. In short, *Patrick* has no bearing on this case and this case has no bearing on the continued viability of *Patrick*.

Nor is HCQIA pertinent to this case. When Congress enacted HCQIA and established an affirmative defense to certain claims arising from certain peer review activities, it expressly provided that HCQIA did not change other "immunities available under law." 42 U.S.C. §11115(a). Thus, Congress did not intend to limit the scope of evolving judicial doctrines, such as the state action doctrine and the *Copperweld* doctrine. *Patrick*, 486 U.S. at 105 n.8.

HCQIA's irrelevance is further demonstrated by the procedural posture of this case. The courts below held that

the Complaint failed to allege an actionable conspiracy. They did not therefore consider whether an affirmative defense, such as HCQIA, might apply. Neither HCQIA nor congressional intent can be twisted to support the petition.[10]

Finally, Petitioner's alarmist rhetoric regarding the anti-competitive abuses that might abound if the lower courts' opinions are allowed to stand must be laid to rest. By no stretch of the imagination does this case extend an immunity that "suffocates competition among physicians." Pet. at 17. This case has no bearing on anticompetitive actions taken by physicians outside the hospital peer review process, or action that is not subject to oversight by a governing body comprised of individuals who do not compete with the complaining physician. In addition, when peer review action is alleged to constitute monopolization or an attempt to monopolize, liability may follow. Thus, the types of abuses highlighted in Sections IV and V of the petition remain subject to antitrust liability under the Seventh Circuit's analysis.

The Seventh Circuit's unpublished, carefully circumscribed opinion will generate none of the iniquities prophesied in

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[10] The GAO Report, *Physician Antitrust Issues—GAO Views*, ¶50,062 Trade Reg. Rpts. 48,714 (1993), cited by Petitioner, is not inconsistent with the Seventh Circuit's Opinion. That Report acknowledged that peer review was largely immune from antitrust scrutiny. The *Copperweld* doctrine is one of the doctrines under which some peer review activities fell outside the scope of the antitrust laws at the time the GAO submitted its Report to Congress. In addition, the Report's observation that "where ultimate power is vested in the Board, rather than competitors of the doctors under review the medical staff may engage in peer without undue exposure" can be read as acknowledging that the medical staff in such cases may qualify for protection under the *Copperweld* doctrine.

the petition and cannot even be cited as precedent in future litigation. Only where a hospital board comprised of non-competitors retains the ultimate authority and responsibility for a peer review decision, soliciting recommendations from physicians pursuant to clearly defined delegations of authority, would the lower court's opinions insulate a hospital and its medical staff from antitrust conspiracy claims. This sound, and almost universally followed, application of the *Copperweld* doctrine and the antitrust injury requirement does not warrant this Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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